

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012924

STATE FILE NUMBER

FILED MAY 11 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 461

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Christian	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Nixa, Rt. #1	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If outside, give location) 4 miles SW	
3. NAME OF DECEASED (Type or print) MARY CHARLOTTE CARR		4. DATE OF DEATH Month May Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Jefferson, Iowa	
13a. FATHER'S NAME Charles Kelley		14. NAME OF HUSBAND OR WIFE Clarence Edward Carr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Subarach- noed hemorrhage. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension & arteriosclerosis DUE TO (c) 2 wks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 330X		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Springfield, Mo.		20g. COUNTY Christian	
20h. STATE Missouri			
21. I attended the deceased from 4-26-59 to 5-7-59 and last saw her alive on 5-7-59 Death occurred at 9:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Gene W. Fawcett (Declarer's title) in D.O.		22b. ADDRESS 808 Medical Arts Bldg. Springfield, Mo.	
22c. DATE SIGNED 5-8-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/11/1959	
23c. NAME OF CEMETERY OR CREMATORY Mem. Park Cemetery		23d. LOCATION (City, town, or county) (State) Waterloo, Iowa	
24. FUNERAL DIRECTOR John Harris		25. DATE RECD. BY LOCAL REG. 5-8-59	
26. REGISTRAR'S SIGNATURE Effie E. Melton			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. no symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Sean Harris*

Licensed Embalmer No. *4390*
P. O. Address *Cleveland, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.